Appendix 7
Sample Prior Authorization Request Form (PA/RF) for Inpatient Hospital Services

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 133

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima D.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: 09/25/1975

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (555) 555-5555

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: 203.0 Multiple myeloma

11 DX: SECONDARY:

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
41.01		1	0	Autologous bone marrow transplant		$100,000.00
W9115		1	C	Acquisition cost		
					TOTAL CHARGE	21 $100,000.00

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE | EXPIRATION DATE | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120